

**PHARMACY  
BOARD  
COMPLAINT  
FORM**

DPH Date Rec'd (stamp)

**DEPARTMENT OF PUBLIC HEALTH**  
DIVISION OF HEALTH PROFESSIONS LICENSURE  
OFFICE OF PUBLIC PROTECTION

TEL (617) 973 - 0865 FAX (617) 973-0985 TTY (617) 973-0895

<http://www.mass.gov/dph/boards/>

**DPH USE ONLY:**

Entered into Database (date) \_\_\_\_/\_\_\_\_/\_\_\_\_ Docket # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Initials \_\_\_\_

**Please complete this form as fully as possible. Please TYPE or WRITE LEGIBLY in ink.**

COMPLAINANT

☐ Mr.  
☐ Mrs.  
☐ Ms.

\_\_\_\_\_  
Your Last Name      Your First Name      Patient's Full Name (if different)      Patient's Age

Your Business Name: \_\_\_\_\_  
(if applicable)

Business Address: \_\_\_\_\_  
Street      City      Zip

Complainant Address: \_\_\_\_\_  
Street      City      Zip

Patient's Address (if different) \_\_\_\_\_  
Street      City      Zip

Your Primary Phone number: (    )      Your Secondary Phone number : (    )      Your Email:

LICENSEE

☐ PHARMACIST      ☐ PHARMACY TECHNICIAN      ☐ INTERN

\_\_\_\_\_  
Licensee's Last Name      Licensee's First Name      Lic # (if known)

☐ DRUGSTORE / PHARMACY  
☐ WHOLESALE DISTRIBUTOR      Phone #: \_\_\_\_\_

Business Address: \_\_\_\_\_  
Street      City      Zip

COMPLAINT DESCRIPTION

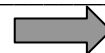
**NATURE OF COMPLAINT:**

- ☐ Medication error      ☐ Impairment      ☐ Practice beyond the scope of practice      ☐ Drug diversion  
☐ Patient abandonment/neglect      ☐ Unlicensed practice      ☐ Criminal conviction/conduct      ☐ Other (specify)

DATE(S) OF INCIDENT(S): \_\_\_\_\_

**DETAILS OF COMPLAINT:** Clearly describe the incident(s) leading up to your complaint. If applicable, **attach copies** of documents such as prescriptions, photographs, witness statements, etc. which support your statements. **DO NOT SEND ORIGINALS.** Attach extra paper as needed to complete this section.

Continue on next page if needed



## Details of complaint (continued)

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Have you discussed this matter with the licensee, the licensee's office or facility ☐ yes ☐ no

If yes, name and phone number of person contacted: \_\_\_\_\_

Date of contact: \_\_\_\_\_ How was contact made? (phone, e-mail, letter, in person) \_\_\_\_\_

Result of contact: \_\_\_\_\_

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Witness name(s) and telephone number(s) (if applicable) \_\_\_\_\_

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Have you filed this complaint with any other state or federal agencies? \_\_\_\_\_ If yes, explain \_\_\_\_\_

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If this complaint is against a person or entity licensed by the Pharmacy Board, **are you willing to testify** in person regarding this matter at a formal hearing?

☐ Yes, I am willing. ☐ No, I am not willing.

## AUTHORIZATION FOR RELEASE OF RECORDS AND REFERRAL OF COMPLAINT

My signature on this form, or photocopy thereof, authorizes the Department of Public Health to:

- (1) receive copies of all my medical, dental, and mental health records relating to my complaint; and
- (2) refer my complaint to other law enforcement authorities for appropriate action.

I understand that all complaints are investigated to determine their factual basis. **The act of filing a complaint and its receipt and/or investigation by DPH does not mean that disciplinary action will be taken against the licensee.**

I hereby declare that I am at least 18 years old and affirm under penalties of perjury that the information provided in connection with the foregoing complaint is true and correct to the best of my knowledge, information and belief.

Signature of \_\_\_\_\_

\_\_\_\_\_ Date

☐ Patient or

☐ Legal Representative, or  
(attach documentation)

☐ Other Complainant

**Mail this form to:**

Department of Public Health  
DHPL Office of Public Protection  
239 Causeway Street, 4<sup>th</sup> Floor  
Boston, MA 02114